PRINTED: 11/16/2011
FORM APPROVED

ivision of Health Care Facilities

.TEMENT OF DEFICIENCIES I PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN9502	A. BUILDING 02 - OFFICE BUILDING B. WING	11/14/2011

IE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANON HEALTH AND REHABILITATION CE	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 832	1200-8-6-.08(2) Building Standards (2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the Tennessee Department of Health Building Standards. The findings included: Observation of the corridor by room 102 on 11/15/11 at 10:30 AM, revealed a stain ceiling tile. This finding was acknowledged by the administrator and verified by the director of maintenance at the exit conference on 11/15/11.	N 832	N832 1200 Building Standards 1.) The ceiling tile was replaced on 11/15/2011. 2.) Other areas of the facility were inspected to ensure compliance with the Fire Safety Standards required. 3.) The Maintenance Supervisor will conduct random inspections to ensure compliance with the TN Department of Health Building Standards. 4.) All finding will be reported to QA and A monthly meetings. Subsequent plan of correction will be implemented and developed as needed. COMPLETED ON 12/09/2011	

n of Health Care Facilities

Nena D. McCelus Administrator 12-02-11

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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